



***The Commonwealth of Massachusetts  
Department of Industrial Accidents  
600 Washington Street, 7<sup>th</sup> Floor  
Boston, MA 02111***

**OFFICE OF INSURANCE**

**Process for submitting Insurer Request Certification Form**

1. Fill out Insurer Request Certification Form (below).
2. Return **ONLY** the certification form to Michael W. Owen, at the address indicated at the bottom of the certification form.
3. Mr. Owen will respond by letter to your office, certifying that the employer is uninsured.
4. Attach the Certification Letter to your original claim form, and submit to our claims office at the following address:

Department of Industrial Accidents  
ATTN: Office of Claims Administration  
600 Washington Street, 7<sup>th</sup> Floor  
Boston, MA 02111

## INSURER REQUEST CERTIFICATION

1.  
I, \_\_\_\_\_, certify that the following attempts were made to  
(Employee Attorney)  
\_\_\_\_\_ to obtain insurer information  
(Employer & Employer's Address)  
regarding the claim of \_\_\_\_\_, an employee of that organization,  
(Employee)  
and that to the best of my knowledge no insurance coverage was in force for that company on \_\_\_\_\_.  
(Date of Injury)

2.  
The following corporate officers/owners were contacted:  
NAME/TITLE                      PHONE                      DAY/DATE/TIME

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3.  
( ) I did approach the place of business.  
( ) I did not approach the place of business. Why not \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4.  
( ) The employee requested the information from his/her employer.  
What was he/she told? \_\_\_\_\_  
By whom? \_\_\_\_\_  
\_\_\_\_\_

( ) The employee did not request the information from his/her employer.  
Why not? \_\_\_\_\_

**All sections of this form must be completed. Any exclusions and/or deletions will be cause for return of the claim application and delay in processing.**

5.  
\_\_\_\_\_  
Employee Attorney  
\_\_\_\_\_  
Attorney Address & Telephone Number  
\_\_\_\_\_  
Claimant

**This form requires BOTH signatures**  
Return to: Department of Industrial Accidents  
ATTN: Michael W. Owen  
600 Washington Street, 7<sup>th</sup> Floor  
Boston, MA 02111